

RULES AND REGULATIONS FOR UTILIZATION REVIEW IN ARKANSAS

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SECTION 1: AUTHORITY AND PURPOSE

The following Rules and Regulations for Utilization Review in Arkansas are duly adopted and promulgated by the Arkansas State Board of Health pursuant to the authority expressly conferred by the laws of the State of Arkansas in Act 537 of 1989, Ark. Code Ann. §§ 20-9-901 et seq.

The purpose of these Rules and Regulations is to promote the delivery of quality health care in a cost effective manner; foster greater coordination between payers and providers conducting utilization review activities; protect patients, business and providers by ensuring that private review agents are qualified to perform utilization activities and to make informed decisions on the appropriateness of medical care; and to ensure that private review agents maintain the confidentiality of medical records.

SECTION 2: DEFINITIONS

For the purpose of these Rules and Regulations the following definitions shall apply:

- A. Board means the State Board of Health.
- B. Certificate means a certificate of registration granted by the State Board of Health to a private review agent.
- C. Director means the Director of the Arkansas Department of Health or his/her designee.
- D. Hospital means any facility established for the purpose of providing inpatient diagnostic care and treatment for two or more unrelated persons for more than 24 hours may not be conducted or maintained in this State without being licensed.
- E. Private Review Agent means a non-hospital affiliated entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of an Arkansas business

entity or third party that provides or administers hospital and medical benefits to citizens of this State including a health maintenance organization or entity offering health insurance policies, contracts or benefits in this state including a health insurer, non-profit health service plan, health insurance service organization, or preferred provider organization.

F. Utilization Review means a system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients. More specifically, utilization review refers to a preservice determination of the medical necessity or appropriateness of services to be rendered in a hospital setting either on an inpatient or outpatient basis, when such determination results in approval or denial of payment for the services. It includes prospective, concurrent or retrospective reviews.

G. Utilization Review Plan means a description of the standards governing utilization review activities performed by a private review agent.

H. Utilization Review Representative means the person(s) in a physician office or hospital designated by the physician or hospital to provide the necessary information to complete the review process.

I. Consulting Physician means a Medical Doctor, Doctor of Osteopathy, Dentist or Chiropractor who possess the degree of skill ordinarily possessed and used by members of his or her profession in good standing engaged in the same type of practice and specialty in the locality where the service under review occurred or in a similar locality.

J. Certified Private Review Agent means a private review agent who meets all the criteria for certification as set forth in these Rules and Regulations, has paid all current fees, and has been assigned a certification number.

SECTION 3: PRIVATE REVIEW AGENTS – APPLICATION FOR CERTIFICATION

A. By December 31, 1990 or a date approved by the Director, a private review agent shall hold a certificate from the Director to conduct utilization review in this State.

B. A private review agent seeking certification shall:

1. Submit an application to the Director in a form that the Director requires;
2. Pay an application fee of \$1,250 per year. This fee is payable in advance for both years of the certification (total \$2,500). This fee applies to the entity doing the review and not to the individual reviewer;
3. Provide supporting documentation as required by this regulation.

C. An application for certification shall be accompanied by all of the following:

1. A utilization review plan which shall include any or all of the following components used by the private review agent to approve or deny payment or recommend approval or denial of payment in advance for proposed or delivered inpatient or outpatient care or retrospectively approve or deny under certain circumstances.
 - a. Elements of review such as:
 1. Prospective review (includes preadmission, admission and preauthorization)
 2. Concurrent or continued stay review;
 3. Reconsideration;

4. Second surgical opinion;
 5. Non-certification or non-authorization;
 6. Lack of information or administrative denial;
 7. Retrospective review;
 8. Bill review.
- b. Policies and procedures for review including:
 1. Any forms or form letters used during the review process;
 2. Time frames that shall be met during the review;
 3. A written protocol describing every aspect of the review process.
 - c. A description of the clinical review criteria and the policies and procedures for updating or modification.
 - d. Review delegation and oversight policies and procedures.
 - e. The provisions, procedures, and time frames by which patients, physicians, or hospitals may seek appeal of an adverse determination by the private review agent including:
 1. A written protocol describing the appeal procedure;
 2. Any forms or form letters which shall be used during the appeal procedure;
 3. Time frames that shall be met during the appeal procedure;
 4. The names and qualifications of personnel making final appeal determinations.
 - f. Quality management program policies and procedures;
 - g. Case management policies and procedures.
2. The name, number, type and qualification or qualifications of the personnel either employed or under contract to perform the utilization review. Any change in the medical director shall be reported to the Director within 30 days
 3. Policies and procedures to verify the current licensure and credentials of utilization review personnel, consulting and appeal physicians, chiropractic physicians, and dentists.
 4. Policies and procedures to ensure that a representative of the private review agent is accessible to patients and providers five days a week during normal business hours in this State; and that a free telephone number be provided with adequate lines available and staffed. The procedure for handling after-hours, weekend and holiday inquiries shall be specified.
 5. The policies and procedures to ensure that all applicable State and Federal laws to protect the privacy, security and confidentiality of individual health information are followed.

- 6. A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan.
- 7. A list of the health plans, health insurers, third party payers or others for which the private review agent is performing utilization review in this State.
- D. A certificate of registration is not transferable.
- E. The application information and all supporting documents as provided by Act 537 shall be held in confidence and not disclosed to the public.

SECTION 4: SPECIFIC ASSURANCES

The following specific assurances must be submitted by all applicants:

- A. To assure confidentiality, a private review agent must, when contacting a physician's office or hospital, provide its certification number, the caller's name, and professional qualifications to the designated utilization review representative in the physician's office or hospital.
- B. The entity providing utilization review will first contact the designated utilization review representative in the physician's office or hospital. Direct contact with the physician will be requested only when necessary information cannot be obtained from the designated representative. The designated utilization review representative must be reasonably available.
- C. Any provider targeted for 100% concurrent review must be provided the reason, in writing, by the private review agent.
- D. Only information necessary to complete the review process submitted under Part III will be collected.
- E. An expedited appeal process shall be available. The physician of record shall have an opportunity to appeal that determination over the phone on an expedited basis. Utilization review organizations shall provide for reasonable access to their consulting physician(s) for such appeals.
- F. Physician or designated utilization review representative shall be notified, as required by Federal Statute 18 U.S.C. S2511, when telephone conversations are being recorded and shall be provided a copy of the conversation upon request. The physician or utilization review representative who records any conversation with a private review agent shall have like responsibility.
- G. Copies of denials shall be furnished at the request of the Director.
- H. Concurrent review will be initiated at a reasonable length of time following admission and at reasonable intervals thereafter. Utilization review organizations will base the frequency of the review on the patient's medical condition. The attending physician and the hospital will be informed of the certified length of stay and the next anticipated review encounter.
- I. A review will be conducted by a physician advisor on a determination not to certify a continued length of stay due to questions of medical necessity or appropriateness. A consulting physician will be reasonably available by telephone to discuss the medical basis for that determination with the attending physician (e.g., criteria, protocols, medical literature).

J. When a determination is made not to certify a continued length of stay, the utilization review organization will notify the physician and the hospital of this decision by telephone supplemented by written notification to the hospital, attending physician and patient.¹ This written notification will include an explanation of the principal reason(s) for the determination not to certify and the procedures to initiate an appeal of that determination if the patient so chooses.

K. If after an initial appeal or request of reconsideration, continued stay is not certified due to questions of medical necessity or appropriateness, the patient or provider will have the right to an additional review by another consulting physician of the appropriate medical specialty.

SECTION 5: PRIVATE REVIEW AGENTS – RENEWAL OF CERTIFICATION

A. A certificate expires on the second anniversary of its effective date unless certification has been renewed for a two year term.

B. Before certification expires, the certified private agent may renew its certification for an additional two year term, if the certified private review agent:

1. Otherwise is entitled to be certified;
2. Pays to the Director the renewal fee of \$2,500; and
3. Submits to the Director:
 - a. A renewal application on the form that the Director requires;
 - b. An update of information as required under Part III of these Rules and Regulations.

C. The Director shall renew the certification of each certified private review agent if the requirements of these regulations are met.

SECTION 6: PRIVATE REVIEW AGENTS – REPORTING REQUIREMENTS

The Director may establish reporting requirements to:

- A. Evaluate the effectiveness of private review agents;
- B. Determine if the utilization review programs are in compliance with the provisions of these Rules and Regulations.

SECTION 7: PRIVATE REVIEW AGENTS – DENIAL OR REVOCATION OF CERTIFICATION

A. The Director shall deny a certificate to an applicant if the Board finds that the applicant does not:

1. Have available the services of sufficient number of registered nurses, medical records technicians, or similarly qualified persons that are supervised by appropriate physicians to carry out its utilization review activities;
2. Meet any applicable provisions of these Rules and Regulations relating to the qualifications of private review agents or the performance of utilization review the Board

¹ The term “patient,” when used through this document, refers to the patient, his/her representative, and/or the enrollee.

adopts relating to the qualifications of private review agents or the performance of utilization review;

3. Have policies and procedures which protect the confidentiality of medical records in accordance with applicable State and Federal laws;
4. Make itself accessible to patients and providers five working days a week during normal business hours in this State.

B. The Director may revoke the certification of a private review agent if the Board finds that the agent:

1. Does not comply with performance assurances;
2. Violates any provision of these Rules and Regulations;
3. Violates any regulation adopted under any provision of this subtitle;
4. Fraudulently or deceptively obtains, attempts to obtain, or uses a certification;
5. Fails to substantially meet the standards and qualifications adopted by the Director;
6. Fails to comply with the regulations adopted by the Board.

C. Before denying or revoking a certificate, the Director shall provide the applicant or certificate holder:

1. Written notice of the reasons for the denial or revocation;
2. Thirty days in which to supply additional information demonstrating compliance with the requirements.
3. The opportunity to request a hearing in accordance with the Arkansas Administrative Procedures Act.

D. If the applicant request a hearing, the Director shall send a hearing notice by certified mail, return receipt requested, at least 30 days before the hearing.

E. An aggrieved party has the right to take direct judicial appeal of a final decision in accordance with the Arkansas Administrative Procedures Act.

F. A person who violates any provision of these regulations is guilty of a misdemeanor, and on conviction is subject to a penalty not exceeding \$1,000. Each day a violation is continued after the first conviction is a separate offense.

SECTION 8: PRIVATE REVIEW AGENTS - EXEMPTIONS

A. The Director may waive the requirements of these Rules and Regulations for a private review agent that operates solely under contract with the Federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act (Medicare) and Title XIX (Medicaid).

B. No certificate is required for utilization review by any Arkansas licensed pharmacist or pharmacy, or organizations of either, while engaged in the practice of pharmacy in this State.

SECTION 9: HEALTH INSURANCE PLAN – INSURER ISSUING HEALTH INSURANCE POLICY – GROUP OR BLANKET HEALTH INSURANCE POLICY

All stated entities under PART III shall have a certificate in accordance with these

Rules and Regulations or contract with a private review agent that has a Certificate of Registration. An insurer that does not meet the requirements of this section shall pay any person or hospital entitled to reimbursement under the policy or contract for claims where medial necessity of a covered benefit has been disputed.

SECTION 10: REPEAL

All provisions of these Rules and Regulations are amendatory to the Arkansas Code of 1987 Annotated.

CERTIFICATION

This will certify that the foregoing revisions to the Rules and Regulations for Utilization Review in Arkansas were adopted by the State Board of Health of Arkansas at a regular session of said Board held in Little Rock, Arkansas, on the 23rd day of January, 2003.

<u>Signed</u>	<u>1/23/2003</u>
Fay W. Boozman, M.D.	Date
Secretary of Arkansas State Board of Health	
Director, Arkansas Department of Health	

The forgoing Rules and Regulation, copy having been filed in my office, are hereby approved.

<u>Signed</u>	<u></u>
Mike Huckabee	Date
Governor	
State of Arkansas	